Commentary

We Tried It Once

Recollections of an Early Government Health Care Program

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Memories of events that occurred half a century ago may not be accurate in all details, and verification is all but impossible, but my memories of certain experiences with a federal health care program when I was serving a locum tenens in a small eastern Oklahoma town (Sapulpa) remain quite vivid. This program illustrates some of the basic problems that can arise in such centrally financed programs.

In early 1941 this region of Oklahoma was still reeling from the effects of the Great Depression of 1929 and from the dust storms that devastated so many thousands of acres of Midwest farmland. The farmers were among the hardest hit, and their medical care was poor to nonexistent. As a result, counties named practicing physicians as county physicians and paid them small annual stipends to render care to indigent patients in their area of the state. Nonemergency patients requiring admission to hospital could be referred, on approval, to the state hospital in Oklahoma City, some 120 miles away. The county physician arrangement was far from satisfactory. Calls from indigent patients were answered after physicians' paying patients were cared for. In addition, as older physicians, county physicians often had finished medical school at one of the diploma mills before the revolution in medical education that followed the Flexner Report.

The indigent patients might have been poor, but they were not stupid. They had long ago ceased to have any confidence in these county physicians' medical ability, consulting them only as a last resort. Indigent patients preferred to see one of the other physicians in town, even if it meant promising to pay a $2 charge when money was available—and it rarely became available—and sitting in the waiting room, at times for half a day, until all the other patients had been treated. Needless to say, most illnesses were treated with home remedies until they ran their course or became serious enough to require admittance to a hospital. Limited funds were available at the local hospital for brief hospital stays for these patients. Longer illnesses required transfer to a state hospital.

In this setting the Federal Farm Bureau—one of its many names over the years—established one of the first programs conducted by the federal government to provide a single payer-capped system of health care. Recognizing the desperate plight of these indigent farm families, the government initiated a federally financed program to provide them with basic medical care. Each state was allocated a certain sum of money based, I suppose, on the estimated number of such families. These funds were then, in Oklahoma at least, distributed to the various counties, again based on need. At the county level the allocation was divided into monthly amounts.

In the first weeks of the program, both the farmers and the physicians were delighted. The farmers found they could consult the physician of their choice and were no longer placed in the back of the room to be seen after all of the other patients. The physicians found that the charges for these services, which had previously been largely written off, were now paid in full, and promptly, by the Bureau.

Unfortunately, this utopian solution was not to last long, and herein may be found some fundamental flaws in that early effort pertinent to any future health care plan. The first downward step came when these poor, previously underserved families began to recognize that some form of medical care was now readily available without charge, and consultations were sought for previously neglected but appropriate health problems. The volume of these unmet needs was grossly underestimated in the original funding. Added to this deficit came another unforeseen factor, an example of the well-known "insatiable appetite" of the public for medical care. Recognizing that they were not only admitted but actually welcomed to physicians' waiting rooms, a trip into town was not complete until nearly every member of the farm family had been examined and a bottle of medicine obtained from the nearby drugstore. Obviously such a demand soon overwhelmed the monthly allocation, and in an effort to honor all of the bills submitted, payments were prorated to fit within the money available for the month. Instead of paying each bill at 100 cents to the dollar, payment was reduced to, say, 95 cents for each dollar billed.

The second downward step followed rather quickly. Physicians, recognizing that their bills were going to be discounted, quietly added the anticipated discount to their bill. In other words, what had been a $2.00 charge for an office visit now became a $2.50 charge. In an effort to con-

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trol the snowballing effect as the prorated payments of these continuously inflated charges became smaller and smaller, one of the first attempts to use a professional standards review organization mechanism was instituted. Two small towns (Sapulpa and Bristow) of about equal population and with about the same number of physicians supplied most of the medical care for the entire county, so with the assistance of the county medical society, a confidential review committee was established in each town. Charges submitted by physicians in Sapulpa each month were reviewed for their appropriateness by the committee in Bristow, and vice versa. Such a review resulted in some modest control of the rapidly escalating costs, but despite continued efforts by the Bureau and the county and state medical societies, the program ended in bankruptcy. Shortly thereafter, the surging economy associated with the entry of the United States in World War II improved farm incomes somewhat and also offered the most marginal farmers an opportunity to earn a livelihood elsewhere.

What might we learn from this long-forgotten attempt at governmental health care, stripped as it was of some of today's compounding factors such as high-tech care, insurance, and administrative costs and legal fees? First, it is financially impossible for any society to provide unlimited health care to its entire population. Restrictions of some type must accompany any plan. But even with such restrictions, the costs must not be underestimated, and realistic budgeting must be in place for any plan to succeed.

Second, the human elements in the equation must not be overlooked—the enormous need perceived by the public for medical attention and the natural impulse of physicians and other health care professionals, as the change is made from one system of medical care to another, to preserve an acceptable level of remuneration. The response of the professionals to the Clinton health care plan recalls a similar reaction when the Medicare program was introduced. The marginal health care that had been rendered to older indigent patients with little hope of compensation before Medicare was now partially paid for, and the costs of the program, in part because of unanticipated demand and in part because of gradually rising provider and other charges, have far exceeded the original estimated expenditure.

We have gained extensive experience with large, federally financed and conducted programs in the past century, but few if any such programs will compare in complexity and size with that which we are now contemplating. As we look forward to the development of a program designed to provide health insurance for everyone, the lessons of a bygone era should not be forgotten.